

Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935
Madison, WI 53708-8935

FAX #: (608) 261-7083
Phone #: (608) 266-2112

1400 E. Washington Avenue
Madison, WI 53703
E-Mail: web@drl.state.wi.us
Website: http://drl.wi.gov

MEDICAL EXAMINING BOARD

APPLICATION FOR RENEWAL OF TEMPORARY EDUCATIONAL PERMIT

TO BE COMPLETED BY THE ADMINISTRATOR OF THE HOSPITAL ONLY IF THE PHYSICIAN IS ENROLLED IN AN AMA OR AOA APPROVED RESIDENCY PROGRAM ACCREDITED BY ACGME IN THE STATE OF WISCONSIN.

I hereby recommend the renewal of the TEMPORARY EDUCATIONAL PERMIT Number _____
issued to _____, who has been employed in this hospital,
(Applicant Name)

_____ Hospital, at _____ for
(Name of Hospital) (Location of Hospital)

the past year as a post-graduate trainee in medicine and surgery under the provisions of Section 448.04(1)(c) of the Wisconsin Statutes. This renewal shall extend the permit for the period of an additional 12 months, and shall expire on _____.
(Date of Expiration of TEP)

Signature of Administrator

Date

Name of Hospital

Address

HOSPITAL SEAL

I _____ make application for renewal of my Temporary Educational
(Applicant)
Permit number _____ issued to allow me to secure post-graduate training at the
_____ Hospital. I request permission for my training to continue for the period of an
(Name of Hospital)
additional twelve months, which privilege shall expire on _____. During the past year I have
conducted _____
(Date of Expiration of TEP)
my activities in this hospital according to the limitations placed upon them by Section 448.04(1)(c) of the Wisconsin Statutes, and by
the regulation of the Medical Examining Board.

My renewal fee of \$10.00 for Permit number _____ is enclosed.

Applicant's Name (Printed)

Applicant's Signature

Date

Current Address:

**RETURN TO THE MEDICAL EXAMINING BOARD
AT THE ABOVE ADDRESS**

#2329 (Rev. 10/06)
Ch. 448, Stats.

For Receipting Use Only